the program when a State court orders the employee to provide health insurance coverage for a child of the employee, but the employee fails to provide the coverage, and for other purposes (Rept. No. 106–492).

H.R. 3995: A bill to establish procedures governing the responsibilities of court-appointed receivers who administer departments, offices, and agencies of the District of Columbia government (Rept. No. 106–493).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. BINGAMAN (for himself, Mr. DOMENICI, and Mr. CONRAD):

S. 3176. A bill to conduct a demonstration program to show that physician shortage, recruitment, and retention problems may be ameliorated in rural states by developing a comprehensive program that will result in statewide physician population growth; to the Committee on Finance.

By Mr. GRASSLEY (for himself, Mr. BREAUX, and Mr. REED):

S. 3177. A bill to require the Secretary of Health and Human Services to establish minimum nursing staff levels for nursing facilities, to provide for grants to improve the quality of care furnished in nursing facilities, and for other purposes; to the Committee on Finance.

By Mr. REID (for Mrs. FEINSTEIN (for herself, Mrs. BOXER, and Mr. AKAKA)):

S. 3178. A bill to amend title 5, United States Code, to provide that the mandatory separation age for Federal firefighters be made the same age that applies with respect to Federal law enforcement officers; to the Committee on Governmental Affairs.

By Mrs. LINCOLN (for herself and Mr. CLELAND):

S. 3179. A bill to promote recreation on Federal lakes, to require Federal agencies responsible for managing Federal lakes to pursue strategies for enhancing recreational experiences of the public, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. EDWARDS:

S. 3180. A bill to provide for the disclosure of the collection of information through computer software, and for other purposes; to the Committee on Commerce, Science, and Transportation.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. MOYNIHAN (for himself, Mr. BYRD, and Mr. SCHUMER):

S. Res. 368. A resolution to recognize the importance of relocating and renovating the Hamilton Grange, New York; to the Committee on Energy and Natural Resources.

By Mr. WARNER (for himself, Mr. INOUYE, Mr. THURMOND, and Mr. STEVENS):

S. Con. Res. 145. A concurrent resolution expressing the sense of Congress on the propriety and need for expeditious construction of the National World War II Memorial at the Rainbow Pool on the National Mall in the Nation's Capital; considered and agreed to.

By Mr. WELLSTONE (for himself and Mr. GRAMS):

S. Con. Res. 146. A concurrent resolution condemning the assassination of Father John Kaiser and others in Kenya, and calling for a thorough investigation to be conducted in those cases, a report on the progress made in such an investigation to be submitted to Congress by December 15, 2000, and a final report on such an investigation to be made public, and for other purposes; to the Committee on Foreign Relations.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

Mr. BINGAMAN (for himself, Mr. DOMENICI and Mr. CONRAD):

S. 3176. A bill to conduct a demonstration program to show that physician shortage, recruitment, and retention problems may be ameliorated in rural states by developing a comprehensive program that will result in statewide physician population growth; to the Committee on Finance.

RURAL STATES PHYSICIAN RECRUITMENT AND RETENTION DEMONSTRATION ACT OF 2000

Mr. BINGAMAN. Mr. President, I rise today with my colleague Senator DOMENICI of New Mexico to introduce legislation that is intended address a significant problem facing some rural states today—a serious shortage of physicians. The bills we are introducing are intended to demonstrate that physician shortages, and recruitment and retention problems can be ameliorated in some rural states by a multifaceted approach, including providing incentives for physicians in training to practice in areas where they are most likely to be needed.

The Council on Graduate Medical Education (COGME) has for some time held the position that the U.S., in the aggregate, has enough, if not too many, physicians. However, COGME's most recent report, published in March 1999, documented that almost half of the counties in our country are designated as Health Professional Shortage Areas—a remarkable finding, given almost three decades of Federal government efforts to address the geographic maldistribution of physicians.

In our State of New Mexico we have physician shortages that are worsening, with certain types of speciality physicians being in the shortest supply. According to 1998 data from the American Medical Association, New Mexico is 20 percent below the U.S. national average of 224 patient care physicians per 100,000 persons. In 15 New Mexico counties, there is no more than 1 physician or less per 1000 population, and 1 New Mexico county has no physician at all to care for its population.

And, Mr. President, New Mexico is not alone. Other rural states are also suffering.

A recent Health Care Finance Administration report showed that there has been a decline over the past 5 years in certain types of specialty physicians either practicing medicine or participating in the Medicare program in many rural states. The worst loss for New Mexico has occurred in thoracic surgery with a 35 percent decline. Several other specialities, such as urology, ophthalmology, and psychiatry, are not that far behind.

The only significant physician growth that can be seen is in primary care and that's still not adequate. With losses occurring in certain physician specialties, problems for all physicians' practices are continuing to worsen—they can't refer patients to specialists without great difficulty. For example, in New Mexico, there have been accounts of patients being referred to ear, nose and throat doctors having to wait up to 9 months for a non-emergency consultation. Without a timely in-state consultation, the patient's primary care physician may have to refer the patient to an out of state speciality physician for care. This is frustrating for the physician, and costly and time consuming for the patient.

As many of you know, New Mexico is one of the nation's poorest states, with a large uninsured population. In 1998, it ranked 48th in the amount of personal income per capita. For many physicians, this means they may never get paid for much of the work they do.

The physician shortage is becoming so severe in our state that last year the New Mexico Medical Society conducted a survey of our physicians to try to find out about how doctors are faring in the state. The response from New Mexico physicians was shocking—42 percent of the physicians surveyed said that they are seriously or somewhat seriously considering leaving their medical practice, and 40 percent said that reimbursement rates are a significant problem. Comments offered by physicians in this survey were very clear—''I make a good income, but to do that I have to work 65–70 hours a week, in, and week out. The reimbursement rates are such that I could move to a lot of nice places and maintain my income and work three-quarters as much. Family life is important.''

Almost weekly, New Mexico newspapers report about problems caused by provider shortages. On September 7th, the Albuquerque Journal carried a story about a women who had fallen, bruised her spinal cord, and rapidly developed paralysis of both hands and arms. She had to wait 18 hours to be seen on an emergency basis because of a critical shortage of neurosurgeons in Albuquerque, New Mexico's largest city. Stories like this one are becoming more and more common. There are many accounts of New Mexicans having to wait up to 9 months for an appointment to be seen by a specialist, and of newborns having to be transported out of state because the neonatal intensive care unit does not have adequate physician coverage.

My offices in Washington, DC, and New Mexico are constantly receiving letters and phone calls, and visits from constituents who want to tell us about physician shortages, physicians leaving the State of New Mexico, and the loss of their individual providers. They can't understand why this happening in a country with the greatest healthcare system in the world.

All of these problems clearly show that New Mexico's health care system